1.2 Organization, Programs, Operations, Strategies and Resources

Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect

Chief Seattle

The IHS is the Operating Division (OPDIV) within HHS charged with administering the principal health program for the eligible AI/AN population. The IHS provides comprehensive health services through its I/T/U system of facilities and programs. Many of the people served by the IHS live in some of the most remote and poverty stricken areas of the country, and these health services represent their only source of health care. In terms of magnitude, the I/T/Us provide health services to over 1.3 million people through 151 service units composed of 550 health care delivery facilities, including 49 hospitals, 214 health centers, 7 school health centers, and 280 health stations, satellite clinics, and Alaska village clinics.

Within this system, Indian tribes deliver IHS-funded services to their own communities with about 44 percent of the IHS direct services budget in 12 hospitals, 155 health centers, 3 school health centers, and 239 health stations, satellite clinics, and Alaska village clinics. Tribes who have elected to retain the Federal administration of their health services at the present time receive services with about 56 percent of the IHS direct services budget in 37 hospitals, 59 health centers, 4 school health centers, and 44 health stations and satellite clinics. The range of services includes inpatient and ambulatory care, extensive preventive care, and a diversity of health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people away from the reservation settings through 34 urban Indian health programs. It is estimated that almost 60 percent of all AI/ANs now reside in or near urban centers and available evidence suggests they have considerable health care needs. The Contract Health Services program is an integral part of the IHS system for purchasing services from non-IHS providers to support, or in some cases in lieu of, direct care services. Contract Health Services represents about 18 percent of the IHS Budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding (i.e., IHS = 59%, Tribal = 41%). In FY 1999, the IHS Fiscal Intermediary processed approximately 360,000 payment claims.

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1994-96, including:

- maternal mortality reduced 78% (27.7 to 6.1 per 100,000)
- tuberculosis mortality reduced 82% (10.5 to 1.9 per 100,000)
- gastrointestinal disease mortality reduced 76% (6.2 to 1.5 per 100,000)
- infant mortality reduced 66% (22.2 to 7.6 per 100,000)
- accident mortality reduced 57% (188.0 to 80.6 per 100,000)
- pneumonia and influenza mortality reduced 50% (40.8 to 20.2 per 100,000)

When compared with the U.S. general population, the IHS achieved these improved outcomes in the face several complicating factors including:

- lower per capita expenditures for health care
- limited availability of providers (e.g., half the physicians and nurses per capita)
- higher costs for providing health care in isolated rural settings (loss of economies of scale)
- lack of facilities in numerous locations and many outdated existing facilities (i.e., average age of IHS facilities is 32 years in comparison to 9 years for the private sector)
- lower utilization of health care services (e.g., 25% annual utilization of dental service for AI/ANs compared to about 60% for US population overall)
- significantly higher health care needs because of poor health status (significantly higher rates of diabetes, alcoholism, injuries, oral diseases, and overall death rate)
- high unemployment, poverty, substandard housing, and other recognized contributing factors to reduced health status

While overall outpatient visits have steadily increased with the AI/AN population growth of over two percent annually, decreases have occurred in access to non-urgent primary services that include:

- 37% decline in the number of well child services between FY 1992-97
- 35% decline in the number of physical exams between FY 1994-97
- 26% reduction in the proportion of people receiving dental services between FY 1992-99
- 68% reduction in water systems fluoridated between FY 1991-99
- 128% increase in denials of claims from health care contractors between FY 1994-99

In this context, the increasing demand for urgent care that has reduced the capacity of the IHS to provide the primary services that are critical to long-term health maintenance and improvement. Of greatest concern are the most recent mortality data (FY 1998) available from the National Center for Health Statistics adjusted for miscoding of AI/ANs. These data document an upward trend in deaths of AI/AN people for the period of 1996-98 compared to the period 1994-96 from cancer, diabetes, suicide, motor vehicle accidents, and heart disease. The net result of these categorical increases is an overall increase in death rate for AI/AN people from 699 per 100,000 population for the period 1994-96 to 715 per 100,000 population for the period 1996-98. With the U.S. general population mortality rate declining during these comparable time periods from 504 per 100,000 population to 479 per 100,000 population, it is clear the health disparity gap relative to AI/AN mortality is worsening. Chart I on the following page outlines these disturbing AI/AN mortality trends.

Chart I
MORTALITY RATE DISPARITIES CONTINUE

American Indians and Alaska Natives in the IHS Service Area
1994-96 to 1996-98 and U.S. All Races 1995 and 1997
(Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 1996-98	U.S. All Races Rate 1997	Ratio: AI/AN to U.S. All Races	AI/AN Rate 1994-96	U.S. All Races Rates 1995	Ratio: AI/AN to U.S All Races
ALL CAUSES	715.2	479.1	1.5	699.3	503.9	1.4
Alcoholism	46.5	6.3	7.4	48.7	6.7	7.3
Tuberculosis	1.5	0.3	5.0	1.9	0.3	6.3
Diabetes	52.8	13.5	3.9	46.4	13.3	3.5
Motor Vehicle Crashes	54.8	15.9	3.4	54.0	16.3	3.3
Suicide	20.2	10.6	1.9	19.3	11.2	1.7
Homicide	14.5	8.0	1.8	15.3	9.4	1.6
Cervical Cancer	4.2	2.5	1.7	3.3	2.5	1.3
Infant Deaths [1/]	8.9	7.2	1.2	9.3	7.6	1.2
Diseases of the Heart	157.1	130.5	1.2	156.0	138.3	1.1
Cerebrovascular Diseases	29.5	25.9	1.1	30.5	26.7	1.1
Malignant Neoplasms (All)	124.0	125.6	1.0	116.6	129.9	0.9
HIV Infection	3.3	5.8	0.6	6.2	15.6	0.4

[1/] Infant deaths per 1,000 live births.

NOTE: American Indian and Alaska Native rates were adjusted to compensate for race misreporting on State death certificates.

Given these trends and challenges, the IHS and its diverse stakeholders have been reorganizing the IHS and are continually developing alternative methods to assure more efficient health programs and administrative support to Indian communities. The redesign efforts emphasize patient care; strengthening government to government relations; streamlining administration and management; quality support services to field-based health care activities; diversification of operations; staffing new facilities; and fair treatment of employees. This performance plan supports and provides quantifiable measures for each of these priorities.

The budget supporting this performance plan proposes provides linkage to a multidisciplinary approach that crosscuts programs key to addressing complex health problems associated with chronic diseases and harmful behavioral health practices. This approach includes enhancing the integration of our diverse expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/Us. Emphasizing prevention strategies throughout the clinical service activities strengthens the community-based public health model. Furthermore, it is essential to maintain community health programs and supporting partnerships with community resources such as public safety programs, schools, and other community based organizations.

The first priority in the budget request is to maintain and in some cases increase access to basic health services for AI/AN people. In this context, the request addresses the multiple health issues affecting the AI/AN population and to assure the health of the AI/AN population does not continue it downward trend. The proposal targets the health problems identified as highest priorities by the I/T/Us and responsible for much of the disparity in health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases, and sanitation.

The support for public health infrastructure is also fundamental to these activities. These investments will maintain surveillance, prevention and treatment services and are based on "best practices" defined in the public health literature. This approach is consistent with the trend of Federal entities adopting such industry standards. Many of the IHS performance indicators for "treatment" and "prevention" represent our commitment to this process.

An essential component of supporting access to services is to assure that there are adequate facilities and equipment for the provision of health services. The IHS must assure an efficient, safe, and pleasant environment for the provision of services by ongoing maintenance, repair, renovation, and replacement of health care facilities. The funding request for these functions is underpinned by performance measures in the section addressing Capital Programming/Infrastructure.

Also critical is the provision of contract support costs to the tribal health delivery system. These requested funds will provide for tribal communities to assure that there are utilities, training, clerical staff, administrative and financial services needed to operate health programs. This investment is consistent with the Administration's commitment to supporting tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Another target of the FY 2002 funding request is water and sewer systems for new and existing homes at the community level to support further progress in preventing infectious diseases and improving the quality of life and is thus specifically addressed in this plan. This performance

plan backs this request with a specific performance measure as part of the Capital Programming/Infrastructure section of this document.

In summary this performance plan and budget request represents a commitment to utilized available resources to the maximum benefit in achieving our mission of improved health status for the AI/AN people.